CHAPTER 72A

REGULATION OF TRADE PRACTICES

72A.20 METHODS, ACTS, AND PRACTICES WHICH ARE DEFINED AS UNFAIR OR DECEPTIVE.

[For text of subds 1 to 11, see M.S.1996]

Subd. 12. **Unfair service.** Causing or permitting with such frequency to indicate a general business practice any unfair, deceptive, or fraudulent act concerning any claim or complaint of an insured or claimant including, but not limited to, the following practices:

(1) misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(2) failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(3) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(4) refusing to pay claims without conducting a reasonable investigation based upon all available information;

(5) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(6) not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;

(7) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds;

(8) attempting to settle a claim for less than the amount to which reasonable persons would have believed they were entitled by reference to written or printed advertising material accompanying or made part of an application;

(9) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured;

(10) making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made;

(11) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(12) delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(13) failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;

(14) failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement;

(15) requiring an insured to provide information or documentation that is or would be dated more than five years prior to or five years after the date of a fire loss, except for proof of ownership of the damaged property.

[For text of subds 13 to 35, see M.S.1996]

History: *1997 c 77 s 3*

72A.201 REGULATION OF CLAIMS PRACTICES.

[For text of subds 1 to 7, see M.S.1996]

Subd. 8. **Standards for claim denial.** The following acts by an insurer, adjuster, or self–insured, or self–insurance administrator constitute unfair settlement practices:

(1) denying a claim or any element of a claim on the grounds of a specific policy provision, condition, or exclusion, without informing the insured of the policy provision, condition, or exclusion on which the denial is based;

(2) denying a claim without having made a reasonable investigation of the claim;

(3) denying a liability claim because the insured has requested that the claim be denied;

(4) denying a liability claim because the insured has failed or refused to report the claim, unless an independent evaluation of available information indicates there is no liability;

(5) denying a claim without including the following information:

(i) the basis for the denial;

(ii) the name, address, and telephone number of the insurer's claim service office or the claim representative of the insurer to whom the insured or claimant may take any questions or complaints about the denial;

(iii) the claim number and the policy number of the insured; and

(iv) if the denied claim is a fire claim, the insured's right to file with the department of commerce a complaint regarding the denial, and the address and telephone number of the department of commerce;

(6) denying a claim because the insured or claimant failed to exhibit the damaged property unless:

(i) the insurer, within a reasonable time period, made a written demand upon the insured or claimant to exhibit the property; and

(ii) the demand was reasonable under the circumstances in which it was made;

(7) denying a claim by an insured or claimant based on the evaluation of a chemical dependency claim reviewer selected by the insurer unless the reviewer meets the qualifications specified under subdivision 8a. An insurer that selects chemical dependency reviewers to conduct claim evaluations must annually file with the commissioner of commerce a report containing the specific evaluation standards and criteria used in these evaluations. The report must be filed at the same time its annual statement is submitted under section 60A.13. The report must also include the number of evaluations performed on behalf of the insurer during the reporting period, the types of evaluations performed, the results, the number of appeals of denials based on these evaluations, the results of these appeals, and the number of complaints filed in a court of competent jurisdiction.

[For text of subds 8a to 12, see M.S.1996]

Subd. 13. **Improper claim of discount.** (a) No insurer or community integrated service network shall intentionally provide a health care provider with an explanation of benefits or similar document claiming a right to a discounted fee, price, or other charge, when the insurer or community integrated service network does not have an agreement with the provider for the discount with respect to the patient involved.

(b) The insurer or community integrated service network may, notwithstanding paragraph (a), claim the right to a discount based upon a discount agreement between the health care provider and another entity, but only if:

(1) that agreement expressly permitted the entity to assign its right to receive the discount;

(2) an assignment to the insurer or community integrated service network of the right to receive the discount complies with any relevant requirements for assignments contained in the discount agreement; and

(3) the insurer or community integrated service network has complied with any relevant requirements contained in the assignment.

(c) When an explanation of benefits or similar document claims a discount permitted under paragraph (b), it shall prominently state that the discount claimed is based upon an as-

signment and shall state the name of the entity from whom the assignment was received. This paragraph does not apply if the entity that issues the explanation of benefits or similar document has a provider agreement with the provider.

(d) No insurer or community integrated service network that has entered into an agreement with a health care provider that involves discounted fees, prices, or other charges shall disclose the discounts to another entity, with the knowledge or expectation that the disclosure will result in claims for discounts prohibited under paragraphs (a) and (b).

History: *1997 c 77 s 4; 1997 c 225 art 2 s 62*